DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

Kathryn P. Jett
Director

Michael S. Cunningham
Deputy Director
Program Services
Division

DMC Monitoring Staff:

Joy Jarfors,
Manager, County
Monitoring Branch
(916) 322-7933

Gloria Woodlock
Supervisor, DMC
Monitoring Section
(916) 322-1935

Bruce Cherubin
Analyst
(916) 322-6694

Jim Cortese
Analyst
(916) 327-9503

JoAnn Coughlin
Analyst
(916) 323-0307

Lorna Flores
Analyst
(916) 327-7050

Gwen Nicholas
Analyst
(916) 445-5529

Clyde Steele
Analyst
(916) 323-1874

Elena Valencia
Analyst
(916) 327-9225

www.adp.ca.gov

Drug Medi-Cal MONITORING *NEWS*

No. 1 **January 2005**

Welcome to the first issue of *Drug Medi-Cal (DMC) Monitoring News* designed to update Counties and Providers about DMC documentation, billing and treatment issues. We hope you find it useful and look forward to hearing your comments about how we can serve you better with this information resource. Email comments and questions to dmcanswers@adp.state.ca.us.

DMC MONITORING POSTSERVICE POSTPAYMENT UTILIZATION REVIEWS TO BE UNANNOUNCED

The Drug Medi-Cal (DMC) Monitoring Section has been reviewing the Postservice Postpayment (PSPP) Utilization Review process in an effort to achieve greater efficiencies. It has been the DMC Monitoring Section's practice to provide advance notice to counties and providers of on-site PSPP reviews.

Beginning January 15, 2005, DMC Monitoring will be moving to unannounced PSPP review visits. An analysis of existing resources, an ever-increasing number of providers to review, traffic congestion and travel delays, have made it impossible to continue the announced visit practice.

The regulations specify that providers must keep patient records available at all times and that both patient records and pertinent financial information must be readily accessible during business hours [California Code of Regulations (CCR), Title 22, Section 51341.1(g) (i) and Section 51476].

Under this new practice, you can expect to be visited by a DMC analyst at any time during regular business hours. When the analyst arrives, you will be handed a list of files that will be reviewed for compliance with DMC regulations, as is the current practice.

Conducted under normal facility operating conditions, the review will also result in an ADP DMC monitors having a better understanding of how the treatment program works.

When the DMC analyst arrives, the county contract person will be notified of the review so that he/she can attend the exit conference.

We welcome your input. Please send your comments or questions to dmcanswers@adp.state.ca.us.

QUESTIONS? CONTACT DMCANSWERS @ ADP...

If you have a DMC question that can't be revealed by consulting Title 22 regulations, which should always be your first line of inquiry, you can email your question to the DMC Monitoring Unit at: dmcanswers@adp.state.ca.us

Future issues of this newsletter will publish responses.

The Five Most Common Areas for Payment Recovery for Deficiencies in Meeting Title 22 Regulations: Document, Document, Document

NOTE: The deficiencies and the regulations discussed here apply to all modalities except Narcotic Treatment Programs (NTP's). NTP providers must follow C.C.R.Title 9 regulations, not discussed in this newsletter.

The five most common payment recovery deficiencies:

1. Admission physical or waiver
2. Treatment plan(s)
3. Individual counseling sessions
4. Group sign-in sheets
5. Progress notes

Common mistakes are occurring in how providers document services and treatment, resulting in deficiencies identified during postservice postpayment utilization reviews. C.C.R.Title 22, Section 51341.1 (k), which governs Drug Medi-Cal (DMC), is very specific about how providers must document their services in order to retain payment.

Here are the five most common areas where deficiencies are found that lead to the largest amount of recouped funds from providers:

1) Admission Physical or Waiver

A physical exam conducted by an M.D., Nurse Practitioner or Physician's Assistant must be completed within 30 days of the client's admission to treatment.

The medical director of the program can waive the requirement of the physical exam after reviewing the client's medical history, substance abuse history, and/or the most recent physical examination documentation.

The most common reasons for recoupments made for this part of the admission process are:

- No record of the physical exam in the client file
- The physical waiver is not clearly worded to identify it as an "admission physical waiver."
- The physician fails to sign and or date the waiver.
- The physician does not state the reason the physical exam is being waived.

Citation in the regulations: CCR, Title 22 Section 51341.1 (h)(1)(A)(iii)]

2) Treatment Plans

A treatment plan must be completed for each client within 30 days of the date he/she is admitted. The treatment plan must include:

- A statement of the problem to be addressed.
- The goals to be achieved for each problem.
- The action steps to be taken to achieve the goals.
- A description of the services that will be provided including the type and frequency of counseling.
- The assignment of a primary counselor.
- Target dates for accomplishing actions steps and goals identified.

The treatment plan is complete and effective on the date of the counselor's signature and must be signed and dated by the medical director within 15 days of that date.

The treatment plan must be reviewed and updated within 90 days of the previous plan and must be signed and dated by the medical director within 15 days of the date of the treatment plan review. [The treatment plan must be updated earlier than 90 days if a change problem or change in the focus of treatment occurs].
Reasons why recoupments are taken for the treatment plan process may include:

- Late signatures by the counselor and/or medical director.
- Signatures are not dated.
- Frequency/type of counseling not identified.
- Target dates for reaching goals not identified.
- Treatment plans are completed late.
- Primary problem statements/action steps/ goals are not related to substance abuse.

[Citation in the regulations: CCR, Title 22 Section 51341.1 (h)(2)(A)]

3) Individual Counseling Sessions

Individual counseling sessions are covered by DMC only on an exceptional basis for Outpatient Drug Free clients. These exceptions include:

- Intake sessions (must be a one-on-one session with a counselor).
- Treatment planning (initial or follow-up).
- Collateral counseling, which are face to face sessions with significant persons, who have personal and not professional relationships with a client's
- Crisis counseling where an actual relapse or imminent threat of

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- relapse because of an unforeseen circumstance.
- Discharge planning.

Common reasons for disallowance of individual counseling sessions include:

- Session does not meet one of the above criteria.
- Progress notes do not identify which of the five reasons is being used to justify the session.
- Progress notes fail to justify crisis intervention.
- Collateral meetings are held with professionals, such as parole agent, Child Protective Services representative, etc.
- Treatment planning sessions held with no treatment plan outcome.
- Intake conducted by office staff rather than one-to-one with a counselor.

[Citations in the regulations: CCR, Title 22 Sections 51341.1 (b)(10),(b)(3), and (b)(5)]

4) Group Sign-in Sheets

Group counseling sign-in sheets are required to be maintained for all group-counseling sessions conducted in all treatment modalities. The sign-in sheet must have the date and duration of the session and clients must individually sign in on the sheet when they attend group. It is best if the sheets are stored in chronological order.

Common problems encountered on sign-in sheets:

- Time/duration/date are missing.
- Client fails to sign-in.
- More than 10 or less than four clients attended group session (does not include Day Care Habilitative and Perinatal Residential modalities).
- One person signs in for all participants.

[Citations in the regulations: CCR, Title 22 Sections 51341.1 (b) (8) and (g) (2)]

5) Progress Notes

Progress notes are individual narrative summaries that must include a description of the client's progress on the problems, goals, action steps, objectives or referrals outlined in the treatment plan. They must also contain information on the client's attendance, including the time, day, month, year of attendance at all group and individual counseling sessions. Common problems with progress notes that result in disallowances:

- The year of the session is not stated.
- Client progress note is not recorded or does not clearly state the progress or lack of progress in terms of the treatment plan.
- Individual counseling session recorded does not meet one of the five DMC qualifying criteria (see above).
- Duration of the counseling session is not noted.

[Citations in the regulations: CCR, Title 22, Section 513141.1 (h) (3)]

IT IS IN THE REGULATIONS....

The Form 7700

The Title 22 Regulations specify under Section 51341.1 (j) (4) and Section 51490.1(d) that the Multiple Billing Override Certification (FORM ADP 7700, revised in 2000) must be placed in each patient record or the second service will be disallowed.

HIPAA Privacy Rule Applies

Because of the Health Insurance Portability and Accountability Privacy Rule, if the form has more than one name on it, all names other than the client's must be blacked out to maintain the privacy and confidentiality of other clients.

If you have not been retaining the ADP 7700 in the client file, you may be subject to recoupment of funds for all second services provided on the same calendar day.

It has come to our attention that because this form involves billing, some counties have been retaining the form. This could result in recoupments.

Please take the time to make sure that your administrative processes include retention of this form in the file. A quality check process can ensure that the ADP 7700 form remains in the client file as required.

If you have questions, contact the DMC Monitoring Section at:

dmcanswers @adp.state.ca.us